NAACOS Policy Recommendations

The National Association of ACOs (NAACOS) appreciates the opportunity to provide details policy recommendations needed to solidify the Medicare ACO program and set Medicare ACOs on a long-term path to success. ACOs offer enormous opportunity for patients and providers to work together to achieve enhanced quality of care, reduced costs and improved health outcomes. As a market-based solution, ACOs rely on groups of physicians, hospitals, and other providers voluntarily collaborating to achieve these important goals. As of 2017, there are 525 Medicare ACOs serving over 10 million beneficiaries and hundreds more commercial and Medicaid ACOs serving millions more patients. In 2016, almost 240,000 physicians participated in Medicare ACOs across the country and many ACOs are governed by physician leaders, which uniquely positions them at the forefront of ACO implementation. The accountable care model has a long history of bipartisan support, starting with the Physician Group Practice Demonstration Program passed under President George W. Bush's administration in 2000 and further expanded under President Obama's administration. ACOs are proving to be one of the most promising solutions to bend the cost curve and provide high-quality patient care and are a premier payment model in the shift to value-based care, which is emphasized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). More time is needed for the ACO model to take root and policy changes, including those detailed in this paper, are critical to enhance the model so it lives up to its potential.

NAACOS is the largest association of ACOs, representing over 3.3 million beneficiary lives through 233 Medicare Shared Savings Program (MSSP) ACOs, Next Generation and Commercial ACOs. NAACOS is an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and healthcare cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process. Our recommendations reflect our expectation and desire to see ACOs achieve the long-term sustainability necessary to enhance care coordination and health outcomes for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

Summary of Key Recommendations

Our recommendations are summarized below and are explained in greater detail in the remainder of this paper. We urge Congress and/or the Centers for Medicare & Medicaid Services to:

- Recognize the important work of ACOs in shifting the industry to value-based care by allowing all ACOs, including those in MSSP Track 1, to qualify for the 5 percent MACRA Advanced Alternative Payment Model (APM) bonuses.

- Finalize plans for a new ACO model, Track 1+, with a more appropriate level of risk based on either a very small percent of total Medicare Parts A and B spending (3 percent in 2018) or on a small percent of physician revenue for covered professional services under the Medicare Physician Fee Schedule (i.e., 8 percent). This model should provide a lower risk option for all ACOs, including those that have hospital participants, and Track 1+ should be designated as an Advanced APM.

- Address the problematic interactions between the MSSP and other CMS/Center for Medicare & Medicaid Innovation (CMMI) programs, which lead to negative unintended consequences that undermine ACOs. Specifically, for Medicare bundled payment programs, ACO assigned beneficiaries should be removed from bundled payments unless a collaborative agreement exists between an ACO and a bundler that is not an ACO participant.

- Develop a mechanism to account for the substantial investments ACOs make (on average, $1.6 million annually) and include these in CMS's determinations of meeting Advanced APM risk under MACRA.

- Recognize the value of the one-sided risk model, which represents approximately 90 percent of MSSP ACOs and allow ACOs to select this option for more than two agreement periods.

- Modify MSSP rebased benchmarking policies to remove ACO-assigned beneficiaries from the regional reference population, account for all savings generated in previous agreement periods by adding those savings back to rebased benchmarks, and allow 2012/2013 ACOs to transition to regionally based benchmarks before 2019.

- Address ongoing concerns and limitations of MSSP risk adjustment by allowing risk scores to increase year-over-year for an ACO's continuously assigned beneficiaries.

- Allow ACOs that are ready to move into a two-sided risk model to do so at the start of any performance year and not require them to wait until the start of their next agreement period.

- Allow ACOs to have the option of choosing prospective or retrospective beneficiary assignment.

- Change the punitive nature of MSSP quality reporting by introducing a quality bonus available for ACOs that do not earn shared savings and by providing, on a sliding scale, up to 10 percentage points of additional shared savings to ACOs in the top half of quality performance or quality improvement.

- Expand the use of payment rule waivers across ACO models by allowing waivers related to: the skilled nursing facility (SNF) 3-day rule, telehealth, home health and primary care co-payments.

- Allow ACOs to real time access the valuable and actionable data in the HIPAA eligibility transaction system (HETS) as it relates to care provided to an ACO's assigned beneficiaries.

- Ensure as few regulatory burdens and reporting requirements as possible for ACOs that must report under the Merit-based Incentive Payment System (MIPS)

- Provide new opportunities for ACOs to increase beneficiary engagement through incentives for beneficiaries choosing high quality, efficient providers that work collaboratively with the ACO.

- Implement a CMS process to automatically reclassify ACO beneficiaries with End Stage Renal Disease (ESRD) into the ACO ESRD benchmark category so their expenditures are correctly accounted for and don't unfairly harm ACO performance as a result of improper beneficiary misclassification.

These policy changes will allow ACOs to collectively flourish and live up to the expectations set when Congress established the MSSP and further emphasized the role of ACOs under MACRA.

Detailed Policy Recommendations

Recommendation: Recognize the important work of ACOs in shifting the industry to value-based care by allowing all ACOs, including those in MSSP Track 1, to qualify for the 5 percent MACRA Advanced APM bonuses.

We are extremely pleased that Track 2 and 3 of the MSSP and the Next Generation ACO Model are on the final list of Advanced APMs. ACOs in these models are dedicated to enhancing the experience of care, improving quality and the health of populations, and reducing per capita costs of health care. We are proud to include many of these ACOs as our members and look forward to working with CMS to refine and advance these ACO models moving forward to ensure their long-term success. However, based on the important contributions, investments and commitment of MSSP Track 1 ACOs, we strongly urge CMS to reverse its decision and include MSSP Track 1 as an Advanced APM. Track 1 ACOs have been at the forefront of the transition to value-based payment models and have significantly invested in their development and early success. As discussed in this letter, some Track 1 ACOs may not be prepared or financially able to assume financial risk and some may never be able to do so. It is more beneficial for CMS, the Medicare trust fund and beneficiaries to keep ACOs in the program to continue their emphasis on improving quality and reducing costs, and classifying Track 1 MSSP as an Advanced APM will help retain ACOs. Therefore, we strongly recommend CMS include Track 1 MSSP as an Advanced APM.

Recommendation: Finalize plans for a new ACO model, Track 1+, with a more appropriate level of risk based on either a very small percent of total Medicare Parts A and B spending for attributed lives or on a small percent of physician revenue for covered professional services under the Medicare Physician Fee Schedule.

We applaud CMS's work to develop Track 1+, which represents an important step to ensure the long-term viability of the ACO model by introducing a new ACO track that incorporates lower downside risk than what is required in existing two-sided ACO models. We also greatly appreciate CMS's determination that Track 1+ will qualify as an Advanced APM under the MACRA Quality Payment Program (QPP). Track 1+ must be designed to incentivize ACOs to begin taking on risk in a manner that holds them accountable for cost and quality but does so in an appropriate way, providing a glide path to assuming risk. Specifically, we urge CMS to lower the benchmark-based risk standard from 4 percent to 3 percent in 2018, which aligns with the minimum Advanced APM requirements. We also strongly recommend that CMS lower the threshold of the Advanced APM benchmark-based risk standard in 2019 and beyond to 1 or 2 percent, and lower the Track 1+ benchmark-based standard to match. This level of risk is more reflective of a true glide path to risk and would be manageable for ACOs that want to continue in the program and begin assuming risk in a responsible manner.

For the Track 1+ revenue-based risk threshold, we recommend CMS first modify the Advanced APM criteria to exclude Part A revenue thus determining the threshold exclusively based on Part B revenue which is also the basis for calculating the Advanced APM bonus. We recommend CMS simultaneously set the Track 1+ maximum revenue-based risk threshold at 8 percent Part B revenue, for all ACOs that select a revenue-based risk model regardless of composition. It is imperative that CMS establish Track 1+ so that it is widely available to ACOs of all sizes and structures and that participation in the model is not restricted to a specific number of agreement periods. Finally, we urge CMS to reconsider its bifurcated approach to determining ACO risk thresholds. Through this method, CMS determines the level of risk that an ACO assumes based on the ACO's composition. A government agency determining the level of risk for a private organization is a government overreach, and we recommend that ACOs be permitted to choose whether they have their maximum risk thresholds based on either a benchmark- or revenue-based standard. Finally, we urge CMS to increase the shared savings rate from 50 to 60 percent for Track 1+ ACOs.

Recommendation: Address the problematic interactions between the MSSP and other CMS/CMMI programs, which lead to negative unintended consequences that undermine ACOs.
CMMI has released a number of programs and initiatives over the last several years which intersect with ACO efforts. This overlap results in conflicting program goals and can have negative consequences for ACOs and the patients they serve. We urge CMS to prioritize population health focused models of care, such as ACOs. Specifically, for Medicare bundled payment programs, ACO assigned beneficiaries should be removed from bundled payments unless a collaborative agreement exists between an ACO and a bundler that is not an ACO participant.

While we support voluntary bundled payment models, we strongly oppose CMMI's use of mandatory bundled and episode-based payment models. The scope of these programs is vast, and the current policies related to the intersection of bundles and ACOs hampers ACOs' ability to succeed. The overlap of these bundled and episode payment programs with ACOs creates conflicts when patients attributed to an ACO are also evaluated under a bundled payment program. Under current CMS policy, a bundled payment participant maintains financial responsibility for the bundled payment episode of care and any gains or losses during that episode are linked to the bundled payment participant and removed from ACO results following the close of the performance year. While CMS is testing an alternative policy by excluding MSSP Track 3 and Next Generation ACO beneficiaries, this exclusion doesn't apply to all MSSP beneficiaries. The problem is exacerbated by the fact that ACOs are not permitted to participate as bundlers. ACOs focus on, and make considerable investments in care coordination and improving care transitions to manage post-acute care effectively. Many successful ACOs credit these efforts for allowing them to achieve shared savings.

CMS and CMMI must create a policy which allows ACOs to voluntarily participate in these bundled payment programs. At a minimum, the savings generated should not be taken away from the ACO entity. The current policy creates conflicting program goals, and hampers ACOs' ability to succeed by deducting the savings from the ACO, when these savings are often generated in large part from the ACO's activities. CMMI must pull back on its aggressive approach of releasing multiple, mandatory bundles in rapid succession.

CMS has also released certain programs which put ACO primary care practices in a difficult position by allowing for programs with similar goals to coexist while excluding ACO practices from participating in such initiatives. An example of this is the Comprehensive Primary Care Plus (CPC+) program which, when first released, excluded ACO primary care practices. That decision, which has since been reversed, caused many practices that were already part of ACOs to consider leaving the ACO to pursue CPC+. What's more, when CMS puts primary care practices in an either/or position, CMS is effectively slowing the adoption of accountability for total cost of care, the greatest opportunity to bend the cost curve. Therefore, we urge CMS to allow ACO practices to participate in such initiatives moving forward.

Recommendation: Develop a mechanism to account for substantial ACO investments
We have repeatedly urged CMS to account for the significant investments ACOs make in start-up and ongoing costs and include these costs as part of the definition and calculation of risk. These investments are for clinical and care management, health IT/population analytics/reporting, and ACO management and administration. Data from the NAACOS 2016 *ACO Cost and MACRA Implementation* *Survey*, to which 144 out of 433 2016 MSSP ACOs responded, estimates an average of $1.6 million in these annual investments. These investments must be included in CMS's determinations of meeting Advanced APM risk under MACRA. We are very disappointed that CMS finalized a policy in its final rule, *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models* (published in the November 4, 2016 Federal Register), that disregards these investments by not including them as part of the definition and calculation of risk. We disagree with CMS's assertion that the agency couldn't objectively and accurately assess business risk without exceptional administrative burden on both CMS and APM Entities to

quantify and verify such expenditures. If CMS carefully defined simple, clear standards for business risk and required documentation and attestation from ACOs, the agency could surely create a method to account for these investments. We also disagree with CMS's claim that business risk is not analogous to performance risk. Both require significant investments from providers and put them at jeopardy of financial losses and should therefore be considered risk.

Congress recognized the principle from the ACO authorizing statute that one of the purposes of creating ACOs is to "encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery." That investment—the cost of switching to a fundamentally different approach to patient care—is in and of itself a substantial risk. ACOs incur these costs with the goal of earning shared savings payments; therefore, ACOs consider and account for their investment costs as risk inherent in MSSP participation. These investments include start-up and operating costs to help fund critical ACO activities designed to improve beneficiary care, enhance care coordination, and reduce unnecessary spending and hospitalizations. We urge the agency to recognize these investment costs and consider them as risk, thus allowing Track 1 ACOs to qualify as Advanced APMs. Specifically, we urge CMS to develop a mechanism to account for the substantial investments ACOs make in order to participate, including those related to clinical and care management, health IT/population analytics/reporting, and ACO management and administration.

Recommendation: Recognize the value of the one-sided risk model and allow ACOs to select this option for more than two agreement periods.

As a portion of total 2017 Medicare ACOs, including those in the MSSP and the Next Generation Model, ACOs in two-sided risk models only represent around 15 percent and within just the MSSP that portion is less than 9 percent. The one-sided Track 1 remains by far the most popular option and from 2012 to 2016 the rate of adoption for Track 1 has been four times the adoption rate of two-sided models. However, ACOs may only remain in Track 1 for two agreement periods before having to move to a two-sided risk model or drop out of the program. With growing pressure for ACOs to take on risk and an arbitrary time limit requiring them to do so in their third agreement, it's important to recognize that ACOs remain in Track 1 for a number of reasons. The levels of risk required in the two-sided models (MSSP Track 2, 3 and the Next Generation ACO Model) are significantly higher than what the vast majority of ACOs can bear and therefore are not viable options for most ACOs. The decision to take on risk is at the heart of an ACO's choice about which model to select and having to potentially pay millions of dollars to Medicare is simply not practical nor feasible for most of these organizations. This type of risk necessitates that ACOs have considerable financial backing. Many ACOs are unable to access investor capital and face barriers to obtaining sizeable credit. Without large enough assets to secure loans, many physician owners are left having to personally guarantee debts and obligations, creating situations where physicians could be responsible for repaying a substantial amount, if not all, of their Medicare income for a particular year.

The challenges of taking on risk are often exacerbated for those in rural areas and safety-net providers, which care for some of the most vulnerable patient populations. These providers tend to have even fewer resources and may struggle to come up with start-up and investment costs, let alone be in a position to assume down-side risk. Even the promise of higher shared savings rates or the ability to utilize waivers afforded to two-sided ACOs is not enough to overcome the barriers to assuming considerable financial risk. Further, ACOs are in the business of delivering care and are not necessarily well equipped to take on what is essentially actuarial risk more typical of a health insurance company.

ACOs that began the MSSP in 2012 or 2013 renewed agreements in 2016 and are on schedule for their third agreements to begin in 2019. This is the first time ACOs will be forced to move into two-sided risk arrangements or quit the program. The MSSP has gained considerable momentum in recent years, and it would be devastating for individual ACOs and for the program to see a mass exodus of 2012/2013 ACOs in the 2019 performance year if regulations are not changed to allow continued participation in Track 1. In a

spring 2016 NAACOS survey, *The ACO Cost and MACRA Implementation Survey,* when asked how likely ACOs are to participate in the MSSP if CMS requires the ACO to share losses, almost half of survey respondents said they definitely would not or likely would not participate. Therefore, we urge CMS to modify regulations during 2017 to allows ACOs to continue participating in one-sided agreements. Swift action is needed by the agency on this issue so that a revised policy is in place by the beginning of 2018 when ACOs are planning for the following year.

Further, the disproportionate emphasis on the goal of reducing costs often overshadows the equally important goal of quality improvement that the ACO model offers which, in the long run, will benefit both patients and the Medicare program generally. Some ACOs may never be able to assume downside risk. Requiring them to do so will result in these ACOs dropping out of the MSSP, which is an unintended consequence and will immediately reduce their incentives to help bend the cost curve in Medicare. We urge CMS to modify existing policies to allow ACOs to remain in Track 1 for more than two agreement periods.

Recommendation: Modify the MSSP benchmark rebasing policy to address methodological flaws that skew incentives and hinder the likelihood of ACO's achieving shared savings.
We appreciate CMS's efforts this past year to address some longstanding flaws with the MSSP benchmarking methodology. The final rule*, Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations* (published in the June 10, 2016 Federal Register), modified the benchmarking methodology to gradually incorporate a component of regional expenditure data into rebased ACO benchmarks. We support this as a general approach and were pleased CMS revised the methodology to factor in regional expenditure data along with historical ACO expenditure data. However, there remain a number of flaws with the MSSP benchmarking methodology which must be addressed. Benchmarking is of the utmost importance to ACOs. It is a fundamental program methodology which determines how ACOs perform individually and is one of the ways CMS evaluates the overall success of the program.

It is imperative the following MSSP benchmarking issues be addressed by the new Administration:

- *Remove ACO-assigned beneficiaries from the regional reference population used for rebased benchmarks*
  CMS finalized its proposal to use all "assignable beneficiaries," including ACO-assigned beneficiaries, in determining expenditures for the ACO's region. The determination of which beneficiaries are included in the regional population is very important since this population is the basis for calculating the regional expenditure data that is factored into rebased benchmarks. Rather than comparing ACOs to themselves and other ACOs, CMS should compare ACO performance relative to fee for service (FFS) Medicare by defining the regional reference population as assignable beneficiaries without ACO-assigned beneficiaries for all ACOs in the region. At the very least, CMS should exclude the ACO itself from the region to prevent an otherwise tautological comparison that essentially double counts those ACO-assigned beneficiaries.

- *Account for savings generated in previous agreement periods by adding those savings back to rebased benchmarks*
  Under previous policy which was reversed through the 2016 rebased benchmarking final regulation, CMS adjusted rebased historical benchmarks to account for the average per capita amount of savings generated during an ACO's previous agreement period by adding a portion of their savings to the rebased benchmark (only for ACOs that have net per capita savings across the three performance years). This policy was finalized in a June 2015 MSSP final rule and was only in effect for 2016 before being changed again. The rationale for this policy, which we supported, was that accounting for the performance of an ACO during its prior agreement period was necessary to

enable ongoing program participation. Without the adjustment, ACOs that perform well in the program see their benchmarks reduced as a result, making it harder and harder to achieve savings in future agreement periods. By not accounting for these savings, some ACOs who previously achieved success in the program will be more likely to drop out since their chances of future success are diminished by an unfairly lower benchmark. We urge CMS to add all savings, including any generated and shared savings, back to rebased benchmarks.

- *Allow greater flexibility for how/when ACOs have a component of regional expenditure data incorporated into their benchmarks*
  CMS finalized a transition timeline to gradually incorporate regional expenditure data over multiple agreement periods. We appreciate introducing this change in a gradual manner and using different proportions of regional expenditure data depending on how the ACO's spending compares to its region. However, we strongly urge CMS to allow ACOs – not the government – to decide the pace at which ACOs make this transition. The goal is for ACOs benchmarks to eventually include a sizeable portion of regional expenditure data, and as long as ACOs meet that goal by a certain time, they should be permitted to make the transition more quickly or slowly than what is dictated by CMS's timetable. Also, of critical importance is to allow 2012/2013 ACOs to have the option to have their benchmarks rebased under the new methodology prior to 2019. That is far too long to wait and some of these organizations may not continue in the program directly as a result of CMS making them wait until 2019.

Recommendation: Address ongoing concerns and limitations of MSSP risk adjustment by allowing risk scores to increase year-over-year for an ACO's continuously assigned beneficiaries.
Risk adjustment is another critical program methodology that deserves close examination and changes to make the methodology fair and accurate. Risk adjustment is used across many CMS programs, including the MSSP and a number of others within traditional Medicare and in Medicare Advantage (MA). While many programs rely on Hierarchical Condition Categories (HCC) risk scores, there are important program variations in how CMS approaches risk adjustment. Unfortunately, CMS has not yet identified nor implemented a consistent best practice for a risk adjustment methodology across Medicare programs. The inconsistent approach to risk adjustment in Medicare helps and harms various programs depending on the details of the methodology.

The MSSP risk adjustment methodology contains policies which unfairly penalize ACOs compared to other programs. Specifically, ACO risk scores for newly assigned ACO beneficiaries (i.e., those not previously assigned) reflect both health history and demographic data. For continuously assigned ACO beneficiaries, CMS considers changes based on demographic data but will only *decrease* risk scores for improved health status and will not increase risk scores for patients that become sicker or develop new conditions over time. This is a fundamentally flawed approach since risk scores for continuously assigned beneficiaries can decrease but cannot increase. In contrast, under MA beneficiaries with lower-than-average predicted costs have their payments decreased incrementally based on their risk profile and beneficiaries with higher-than-average predicted costs have their payments increased incrementally based on their risk profile. Therefore, MA has an inherent advantage in its model design which allows and financially rewards risk score increases.

It is unreasonable to assume an ACO or any other provider organization, however effective, can manage a population such that patients don't develop new health conditions, that conditions never worsen over time and the ACO never carries a higher overall disease burden. We urge CMS to address the flawed MSSP risk adjustment methodology for continuously assigned beneficiaries by allowing risk scores to increase as a result of changes in health status. At a minimum, for the MSSP CMS should apply a similar approach used under the Next Generation ACO model where CMS will increase the financial target by up to 3 percent if the population's risk status increases.

Recommendation: Allow ACOs that are ready to move into a two-sided risk model to do so at the start of any performance year and not require them to wait until the start of their next agreement period.
An important consideration for ACOs hoping to qualify as Advanced APMs relates to the MSSP three-year agreement periods. Currently, ACOs may only switch MSSP tracks at the start of a new three-year agreement, and once that period begins they are locked into their decision until their next agreement. As ACOs consider their options for the future, it is essential that CMS adopt a more flexible policy to allow ACOs to move into two-sided risk models earlier than the start of their next agreement period. We urge CMS to modify MSSP participation agreement rules to allow ACOs to voluntarily move into a two-sided risk model at the start of any performance year rather than having to wait until the start of their next agreement period. This is especially important given the current timeframes under MACRA and the length of the agreement periods. For example, ACOs entering into MSSP agreements for 2017 did not have final information from CMS on what qualifies as an Advanced APM until after they had to make their decision for 2017 ACO participation, which binds them to a particular track until 2020. Given that the 5 percent MACRA APM bonus is only in effect for a few years with the last performance year proposed for 2022, it is incredibly unfair to lock ACOs into decisions they must make at a certain time based on other CMS deadlines when they do not have final or updated CMS policies in place to guide them.

We recognize CMS's goal to ultimately move ACOs to two-sided risk models; therefore, it is in the agency's interest to find ways to accelerate this process for interested ACOs. Allowing ACOs to move to a risk-based model early would position the ACO to best balance their exposure to and tolerance for financial risk and would create a flexible glide path towards risk. We urge CMS to modify MSSP participation agreement rules to allow ACOs to voluntarily move into a two-sided risk model at the start of any performance year rather than having to wait until the start of their next agreement period.

Recommendation: Allow ACOs to have the option of choosing prospective or retrospective beneficiary assignment.
Beneficiary assignment has a significant effect on ACO performance and an ACO's ability to best utilize resource to focus on a specific patient population. For Tracks 1 and 2, CMS uses preliminary prospective beneficiary assignment with final retrospective beneficiary assignment. For Track 3, CMS uses prospective beneficiary assignment, which relies on the same stepwise assignment methodology used for Tracks 1 and 2 but assigns beneficiaries to Track 3 ACOs prospectively at the start of the performance year. Under this method, there is no retrospective reconciliation resulting in the addition of new beneficiaries at the end of the performance year. This approach provides a more predictable benchmark and a more stable beneficiary population on which the ACO can focus its efforts. We support allowing ACOs in all tracks to have the option of choosing prospective or retrospective assignment and request CMS modify MSSP assignment to allow this choice.

Certain ACOs, such as a small ACO worried about dropping below the 5,000-beneficiary minimum may prefer a model where it can add beneficiaries throughout the year, and would thus prefer the retrospective assignment model. However, other ACOs would likely prefer a prospective model, which would help them stabilize their beneficiary population and thus avoid volatile benchmark changes. Moreover, advanced ACOs typically employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible. Further, providing a choice between retrospective and prospective assignment would benefit Track 1 and 2 ACOs that may prefer to become accustomed to prospective assignment or may be eligible for payment waivers as a result of their assignment choice. For example, under Track 3, CMS permits a waiver of the Skilled Nursing Facility (SNF) 3-Day Rule. CMS has previously noted it limits this payment waiver to Track 3 because it has prospective beneficiary assignment. While we argue that CMS should allow all ACOs, regardless of their assignment methodology, to use this and other payment waivers, by allowing ACOs in all tracks to select prospective assignment, CMS could provide broader use of payment rule waivers as the population to which the waivers would apply would be easier to define.

Recommendation: Change the punitive nature of MSSP quality reporting by introducing a quality bonus available for ACOs that do not earn shared savings and by providing increased shared savings opportunities for ACOs with better than average quality performance or quality improvement. Currently, an ACO that achieves CMS's established quality performance levels is not rewarded and is instead merely prevented from forfeiting the shared savings payments it has earned. There is no direct financial reward for improving quality of care, and there is no penalty for poor quality unless the ACO has generated savings. This lack of reward can be a strong disincentive for ACOs to invest in quality improvement. Many efforts to improve the quality of care consume ACO resources and increase spending relative to the ACO's financial benchmark in the short term, even if they decrease Medicare spending over the long term. The more an ACO strives to improve quality performance, the more it often needs to spend. If the services used to improve quality are billable services, they will increase the ACO's spending and reduce the probability of beating its benchmark.

Therefore, we urge CMS to instead use an approach similar to that used for Medicare Advantage (MA) by properly rewarding ACOs for high quality. Specifically, CMS should recognize high quality performance compared to established measure thresholds as well as to recognize and reward quality improvement relative to an ACO's previous performance. Therefore, to emphasize and reward above average quality performance or improvement, we urge CMS to provide on a sliding scale up to 10 percentage points of additional shared savings to ACOs scoring in the top half of total ACO quality performance or quality improvement. Additionally, we urge CMS to add a bonus opportunity for ACOs whose quality performance is exceptional, but did not meet criteria for shared savings. Adding this bonus opportunity will more appropriately incentivize quality improvement.

Recommendation: Expand the use of payment rule waivers across MSSP tracks by allowing waivers related to: the skilled nursing facility 3-day rule, telehealth, home health and primary care co-payments. Currently CMS affords certain ACOs relief from a number of cumbersome payment rules which actually prohibit care coordination and can increase costs. We urge CMS to expand the use of these payment rule waivers to extend to all ACOs. This includes the SNF 3-day rule. Eliminating the requirement of a 3-day inpatient stay prior to SNF (or swing-bed Critical Access Hospital admission) will allow ACOs to provide the right care for the patient in the most appropriate location. We also request that CMS waive certain telehealth billing restrictions to increase the use of these services by all ACOs. Specifically, elimination of the geographic components of the originating site requirements will allow all ACOs to have the ability to provide needed telehealth services in areas other than those classified as rural areas by CMS (currently defined as a rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract). We also request that CMS allow beneficiaries to receive telehealth services from their place of residence.

Additionally, we urge CMS to waive certain post-discharge home visit supervision requirements to allow for broader use of these services by ACOs when clinically appropriate. We ask that CMS allow physicians to contract with licensed clinicians to provide these home visit services using general instead of direct supervision requirements specified at 42 CFR § 410.32(b)(3). This will provide all ACOs with needed flexibility during the critical post-discharge time period. Finally, we ask CMS to afford all ACOs with the ability to provide waived co-payments for primary care services provided by the ACO's providers to encourage patients' use of these critical services. CMS should afford all ACOs with every opportunity for success in reducing costs for its patients by allowing ACOs to use these high value services, and we request that these waivers apply to all ACO models.

Recommendation: Allow ACOs to access the valuable and actionable data in the HIPAA eligibility transaction system (HETS) as it relates to care provided to an ACO's assigned beneficiaries.
There is broad consensus among researchers and policymakers that giving timely, actionable data to healthcare providers allows them to work closely with beneficiaries to effectively manage chronic conditions or prevent health conditions from worsening. Indeed, many ACOs are successful because of their focus on care coordination for chronic conditions, emphasis on providing the right care in the right setting, and preventing avoidable and costly complications or hospital readmissions. However, in order to effectively manage a beneficiary's health, ACOs need timely data from CMS. While the agency provides some of this data to ACOs, such as through the Claim and Claim Line Feed (CCLF) files, it is delayed by weeks or months and is, therefore, not always actionable. For example, if an ACO assigned beneficiary goes to the hospital, information is transmitted from the hospital to CMS and back to the hospital through the HIPAA 270-271 eligibility transactions. The data available in HETS is very meaningful and should be provided in real time to ACOs for their prospectively assigned or preliminarily assigned beneficiaries. This would allow ACO providers to communicate with treating providers at the hospital and to work with the beneficiary upon his or her release to ensure optimal treatment, medication adherence and follow up care. We urge CMS to develop a mechanism to share HETS data with ACOs in real time to enhance care coordination, improve outcomes and reduce costs.

Recommendation: Ensure as few regulatory burdens and reporting requirements as possible for ACOs that must report under the Merit-based Incentive Payment System (MIPS)
ACOs participate in a myriad of reporting requirements to comply with MSSP terms. For example, ACOs currently must monitor, track and report on 31 quality measures under MSSP. This is a resource intensive task involving many of an ACO's clinicians and operational staff. It is critical that CMS leverage this work that ACOs are already doing by minimizing duplicative reporting requirements and other regulatory burdens associated with MIPS for ACOs. CMS has finalized an APM Scoring Standard under MIPS which would minimize reporting burdens for ACOs by utilizing quality reporting done by the ACO for purposes of MIPS. This is a step in the right direction, and NAACOS is pleased that CMS has accepted our recommendations in this area.

However, we urge the new administration to make further refinements to MIPS requirements for ACOs to reduce reporting burdens under the Advancing Care Information (ACI) performance category of MIPS, which is also used for purposes of ACO performance evaluation. Specifically, NAACOS urges CMS to adopt a simpler approach to ACI reporting and evaluation to reduce administrative burdens in this area. We also request that CMS maintain a 90-day reporting period in the ACI performance category to allow organizations time to adapt to changes in Electronic Health Record (EHR) technologies that often take place throughout a performance year. We urge CMS to keep MIPS related regulatory burdens at a minimum for ACOs so they can continue to focus on their primary goals associated with the MSSP and Next Generation ACO programs to focus on population health for their patients while reducing costs and improving quality.

Recommendation: Provide new opportunities for ACOs to increase beneficiary engagement through incentives for beneficiaries choosing high quality, efficient providers that work collaboratively with the ACO.
Currently, a flagship of the MSSP program is the freedom of choice patients are provided when seeking services from ACOs. While NAACOS supports the ability of patients to choose their health care provider, there are certain instances when this freedom of choice creates an insurmountable obstacle for ACOs trying to coordinate a patient's care and provide the highest quality care possible. For example, an ACO should have the ability to incentivize a patient scheduling a knee replacement to seek care from the most efficient providers in the area, with whom the ACO may also better coordinate the patient's care. This would also allow for the ACO to reduce unnecessary or inappropriate utilization of services.

Therefore, we urge CMS to allow ACOs to request patients obtain their healthcare services from the ACO's approved list of preferred clinicians and to provide beneficiaries incentives to do so. This will allow ACOs to direct patients to the most cost effective and high quality providers, thereby also resulting in cost savings for the ACO and Medicare. This can be achieved by creating lower co-payments for patients seeking care from the ACO's preferred clinician list to encourage a patient's use of high quality providers with whom the ACO has a relationship and can therefore better coordinate care, while also allowing patients the freedom to see any provider they choose. Given the large financial investments required of ACOs, it is critical that CMS also provide ACOs with the tools they need to succeed. This change is a much-needed improvement to the current ACO model and we urge CMS to make these adjustments to the current program requirements for all ACO tracks and models to give ACOs the ability to modify care delivery to more efficiently coordinate an ACO patient's care.

Recommendation: Implement a CMS process to automatically reclassify ACO beneficiaries with End Stage Renal Disease (ESRD) into the ACO ESRD beneficiary benchmark category so their expenditures are correctly accounted for under MSSP evaluations.

The MSSP classifies beneficiaries into four categories, one of which is for beneficiaries with ESRD. This category often has a significant effect on ACO benchmarks because ESRD beneficiary expenditures are often considerably higher than expenditures for those without ESRD. Beneficiaries who apply for Medicare based on their ESRD status are included in the ESRD beneficiary category, and typically the only beneficiaries to do this are those who only qualify for Medicare based on their ESRD status. Beneficiaries who have existing Medicare coverage based on their age rarely update their beneficiary eligibility status since they have no real reason to do so considering they can access ESRD treatment as part of their normal Medicare benefits. They do not need to be specifically classified as ESRD-eligible for Medicare, which would be required if they were under age 65.

The resulting impact on ACOs is that these beneficiaries are not properly classified for purposes of the ACO benchmark. Beneficiaries age 65 and older who develop ESRD and do not have their benefits reclassified by the Social Security Administration remain in another benchmark category such as aged/non-dual eligible. This misclassification can inappropriately drive up costs under other benchmark categories and ultimately skew ACO benchmarks. Improper beneficiary classification unfairly harms ACO performance by distorting expenditures and benchmark evaluations in a manner that is not reflective of reality. We urge CMS to address this methodological flaw by automatically assigning beneficiaries to the ESRD beneficiary category based on claims data, rather than exclusively rely on the Social Security Administration's classifications, which are often not updated or accurate.

Conclusion

ACOs play an integral role in moving the health system into a new era of high quality, integrated care designed to benefit patients, and reduce unnecessary costs and utilization. We urge CMS to consider the feedback included in this paper and to act on our recommendations which are necessary to strengthen the Medicare ACO model for the future.